Alaska Dental Health Aide Program

Alaska Program. PDF

In 1999, a study found that Alaska Native children experience caries rates 2 ½ times that of the national rate. In addition, dentist workforce data revealed that Alaska Tribal programs experience a 25% vacancy rate and a 30% average annual turnover rate. The Alaska Dental Health Aide program is operated by Alaska tribal health programs. This program is authorized by federal law only for operation in Alaska and does not fall within the parameters of the Alaska State Medical or Dental Practice Acts.. The focus of the program is on prevention, pain and infection relief and basic restorative services. The reorganized categories of dental health aides are:

- Primary Dental Health Aides: will provide dental education, dental assisting, preventive dentistry services;
- Expanded Function Dental Health Aides: will serve as expanded duty dental assistants in regional dental clinics;
- Dental Health Aide Hygienists: will provide dental hygiene services in regional dental clinics and villages; and
- Dental Health Aide Therapists: will provide oral exams, preventive dental services, simple restorations, stainless steel crowns, extractions and take x-rays.

Washington ABCD Program

http://www.abcd-dental.org/index.html

ABCD focuses on preventive and restorative dental care for Medicaid-eligible children from birth to age six, with emphasis on enrollment by age one. It is based upon the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping to control the caries process and reduce the need for costly future restorative work.

Creating an ABCD Program requires: 1) Buy-in from about one-half of dentists who agree to be ABCD providers under an enhanced Medicaid dental fee. 2) A Local government to gain eligibility for federal HCFA funds and to provide caseworkers to do outreach. 3) An oversight task force and a educational organization willing to develop and deliver the program training.

Kids Get Care (King County and Seattle)

http://www.metrokc.gov/health/kgc/index.htm

The Kids Get Care Oral Health Program creates opportunities to expand preventive oral health activities in the community, regardless of insurance status, by: 1) partnering with community based organizations to extend preventive oral health services in low income communities, 2) training primary care medical providers and staff to increase risk assessment activities and the delivery of preventive oral health services, and 3) partnering with the Seattle King County Dental Society to recruit private sector dentists to serve Medicaid children in hub site communities through the ABCD program.

Kids Get Care has improved children's health in a cost-effective way and its *basic tenets* have sparked system improvements in the organizations with which it has connected. Rather than handing uninsured children an insurance card and wishing them luck in obtaining services, Kids Get Care reverses this sequence by first attaching the child and family to a medical home and health services, and then helping establish eligibility for public coverage. Case managers have been trained to look at the child's overall wellness and to get the family involved with multiple health care providers and community programs.

Kids Get Care Recipe http://www.metrokc.gov/health/kgc/recipe.htm

Kids Get Care Recipe.PDF

Oregon Board of Dentistry – Dental Assisting

Oregon Dental Assistant Rules: http://www.oregonvos.net/~jbones/d_assist.htm

Federal loan repayment grants

http://nhsc.bhpr.hrsa.gov/applications/lrp_05/index.asp

Loan repayment for dentists and dental hygienists available through National Health Service Corps

The National Health Service Corps, a division of the U.S. Department of Health and Human Services, is accepting applications for its 2005 loan repayment program. The program helps to ensure an adequate supply of health professionals to provide primary health services to people living in designated "health professional shortage areas." Program applicants must be trained health professionals who agree to provide primary care services in these designated shortage areas for two years.

In return, the National Health Service Corps will help the participating clinicians to repay their educational loans. Eligible clinicians include general dentists and dental hygienists. Applications must be postmarked by March 25.

Ohio State Dental Board

Duties of Dental Hygienists and Dental Assistants: http://www.dental.ohio.gov/duties.pdf

Citizens' Watch for Oral Health Campaign

http://www.kidsoralhealth.org/

This group was formed in Washington State in response to the Surgeon General's report on oral health. They list policy and legislative goals:

- Encouraging the inclusion of oral health into well baby checks-ups
- Promoting and protecting advances in community water fluoridation
- Working with pharmacists and home health care aides to ensure oral health messages are incorporated into seniors' medication management
- Promoting the "prevention as a priority" message into the Priorities Of Government budget process
- Building support for proposals to improve children's oral health
- Helping legislators and candidates for public office understand the cost-savings associated with prevention and translating that understanding into policies
- Maintaining relationships with coalition partners and build grassroots support necessary to promote oral health as an important health issue
- Working to defeat any legislation that interferes with the ability of local jurisdictions to fluoridate local water supplies.
- Protecting and enhancing funding for oral health access around Washington state, such as the Access to Baby and Child Dentistry program.
- Promoting healthier choices for school vending machines, including fluoridated bottled water.
- Leveraging the Priorities of Government budget process used in 2003 to emphasize the cost savings from increased prevention. Securing funding to identify effective prevention programs statewide and to quantify the benefits and cost-savings of prevention.

TennCare

TennCare was initiated, January 1, 1994, because of a looming fiscal crisis posed by federal tightening of rules on the use of provider taxes to fund Medicaid. Twelve managed care organizations (MCOs) were selected based on their ability to provide a comprehensive set of medical services round-the-clock and to meet minimum standards related to cost control, quality assurance, and financial solvency. TennCare was financed by pooling federal and state Medicaid funds as well as other public and private funds used for low-income patients.

Despite conflicting evidence on the impact of TennCare on insurance coverage, the best evidence suggests that the program reduced the number of uninsured by at least one-third. TennCare has been particularly successful in improving coverage of the uninsurable or high-risk individuals with very limited access to private coverage, although at a very high cost to the state. Although TennCare actually spent less than originally projected, it cost $3.8 billion more in its first five years than if Tennessee's Medicaid program had merely grown at the same rate Medicaid programs grew nationally; in effect the higher expenditures were all attributable to the large expansion in coverage.
The Role of TennCare in Health Policy for Low-Income People in Tennessee: http://www.urban.org/UploadedPDF/occa33.pdf (This is extremely long but pages 6 to 21 give a good background and summary of their conclusions.)

TennCare Support from the Wisconsin Dental Association (August 2004): WDA Letter on Tennessee Success

Most recent information on efforts to save TennCare: http://www.nytimes.com/2005/01/11/national/11tennessee.html Gov. Phil Bredesen announced Monday that he would drop 323,000 adults from the state's expanded Medicaid program, but would preserve health coverage for their children. The announcement capped weeks of negotiations between Mr. Bredesen and health care advocates in an effort to save a state program that offers coverage to the working poor whose income is above eligibility limits for regular Medicaid. The governor's plan ends coverage for adults who make more than the Medicaid cutoff, but retains it for more than 100,000 children whose families fall in that range. It would save $1.6 billion a year.

Xylitol Chewing Gum

Xylitol is a sweet-tasting substance found in small quantities in some berries. Research has found that xylitol can reduce tooth decay. You need to chew one or two sticks of the gum for five minutes three times a day after meals. Studies show that this program can reduce tooth decay up to 62%. Nordic schools commonly have school programs where gum containing Xylitol is used by children in fighting tooth decay. The programs are popular, and effective, with children.

Xylitol Research: Xylitol Research.DOC and Army Oral Fitness Paper on Xylitol.PDF

Michigan Healthy Kids Dental

In 2000, Michigan's Medicaid dental program initiated Healthy Kids Dental, or HKD, a demonstration program offering dental coverage to Medicaid-enrolled children in selected counties. The program was administered through a private dental carrier at private reimbursement levels.

Under HKD, dental care utilization increased 31.4 percent overall and 39 percent among children continuously enrolled for 12 months, compared with the previous year under Medicaid. Dentists' participation increased substantially. Costs were 2.5 times higher.

Maine “Tubs by Topic” Oral Health Education Program

Maine Education Tubs by Topic

ABOUT MAINE'S COORDINATED SCHOOL HEALTH PROGRAM

Efforts to improve school performance that ignore health
are ill-conceived, as are health improvement efforts that ignore education.
- National Commission on the Role of the School and the Community in Improving Adolescent Health (1990)

The Coordinating School Health Programs initiative is a joint collaboration between the Maine Department of Education and the Maine Department of Human Services.

A Coordinated School Health Program (CSHP) is an effective system designed to connect health with education. This coordinated approach to school health improves students' health and their capacity to learn through the support of families, communities and schools working together through prevention and intervention.

A Coordinated School Health Program can . . .
1) reduce absenteeism and classroom behavior problems, 2) improve classroom performance, and 3) better prepare students to be productive members of their communities.

EIGHT COMPONENTS OF MAINE COORDINATED SCHOOL HEALTH PROGRAM

1. Youth, Parent, Family, Community Involvement: Encourage the participation of parents and youth in policy development and school involvement. This includes the integration of community providers with schools.
2. Comprehensive School Health Education: Kindergarten through high school health education curriculum that is sequential, developmentally appropriate and includes instruction and assessment.
3. Physical Education & Physical Activity: Physical education classes that promote physical fitness, motor skills, social and personal interaction and life-long physical activity.
4. School Counseling, Physical & Behavioral Health Services: Physical health and behavioral health services including substance abuse services that meet the needs of all students.
5. Nutrition Services: Food and snacks available at school and at school events that are balanced and nutritious.
6. Health Promotion & Wellness: Work-site health promotion programs that encourage and support staff in pursuing healthy behaviors and lifestyles.
7. Physical Environment: Safe and aesthetic physical structure, school grounds and transportation.
8. School Climate: A school atmosphere supported by programs and policies that nurture positive behavior, assure safety and promote a feeling of belonging and respect for all students.

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Dental School Curriculum Addresses Disparities

October 2002: Model dental school curriculum to address disparities in oral health care
In an ambitious effort to bring dental care to vulnerable populations, the University of Illinois at Chicago College of Dentistry is developing a novel community-based educational program that will place students in clinics serving minority, low-income and medically compromised people throughout the city and state.

Expected to serve as a model for dental schools across the country, the program is being developed under a $1.5 million grant from The Robert Wood Johnson Foundation to address what the U.S. Surgeon General calls "profound and consequential disparities in the oral health of our citizens."

The UIC program is intended to bring dental care and prevention services to underserved urban and rural populations and increase the diversity of the dental workforce in the state by recruiting more minority and low-income students into the profession.

"We hope to create a healthcare workforce committed to treating oral diseases in vulnerable populations," said Linda Kaste, director of predoctoral dental public health at UIC. "Future practitioners will start thinking not just about who is in the chair, but who is not in the chair -- who needs dental care and disease prevention and how those services can be delivered." "The college is no stranger to outreach," said Dean Bruce Graham. "But the new curriculum will make community collaboration an integral part of the dental school program."

Over the five-year term of the grant, UIC will work in partnership with community clinics, charitable organizations, government health departments and healthcare systems to identify locations where dental students can do clinical rotations.

According to William Knight, assistant dean for patient care and clinical education, the revised curriculum will provide community-based experiences for students starting in their first semester of dental school and continuing throughout their education. First-year courses will include prevention, dental public health, research, community-oriented healthcare, behavioral science, cultural sensitivity, ethics, quality assurance and practice management. In the fourth year, students will have at least 60 days of clinical experience in the community.

Full scholarships funded by the foundation grant and the UIC College of Dentistry will allow the recruitment of students from underrepresented groups.

According to statistics collected by the American Dental Education Association, only 4.8 percent of dental students are African American and only 5.3 percent are Hispanic -- percentages that do not reflect the general U.S. population.

The new UIC program was inspired in part by the first-ever U.S. Surgeon General's report on the nation's oral health, issued in May 2000, which estimated that 25 million Americans are living in areas lacking adequate dental care services. Particularly vulnerable, the report said, were the poor, ethnic and racial minorities, and medically compromised patients. It urged a national partnership to remedy the situation.

In Illinois, more than 80 percent of counties have a shortage of dental health professionals. Chicago has the highest percentage of children with untreated dental decay in the state.

The Robert Wood Johnson Foundation, based in Princeton, N.J., is the nation's largest philanthropic organization devoted exclusively to health and healthcare. It has given grants to 10 dental schools, including UIC, to develop community-based education programs.